STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Rehabilitation and Healthcare	1400 Medical Park Dr Fort Wayne, IN 46825

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure monitoring of adequate hypochlorite (sanitizer) use in the facility dishwasher and sanitary food handling during food service. 82 of 82 residents residing in the facility were served food prepared in the facility kitchen. Findings include:1) During a kitchen tour, on 02/15/2026 10:00 AM, Dietary Aide (DA) 2 was observed pulling a rack of wet dishes out of the dishwasher and reloading the dishwasher with dirty dishes. In an observation, on 02/15/2026 10:18 AM, DA 2 and DA 4 were in the dish room washing dishes, with 3 racks of wet dishes observed in the clean area. The Dietary Manager (DM) dipped a test strip into the filled dishwasher testing well during the sanitizing cycle. The test strip turned lavender in color, slightly darker than the 25 parts per million (PPM) indication on the test strip color guide, but not as dark as the 50 ppm color indicator. The DM ran two additional dishwasher cycles, inserting at test strip during the sanitizing cycle with the same color resulting. In a record review, on 02/15/2026 10:20 AM, a document titled Sample Dish Machine Temp Log- Low Temperature, dated February, 2026, indicated staff should allow the dish machine to complete wash and rinse cycles and indicate temperatures and PPM on the log. The document indicated the minimum wash temperature was 120 degrees and sanitizer PPM should be between 150 and 400. The log contained spaces for wash temperatures, PPM, action, and employee initials for breakfast, lunch, and dinner meals each day. Blank spaces with no data recorded were found on the forms for the following times:2/3/26 PPM reading for dinner (only temperature recorded)2/5/26 dinner2/6/26 breakfast, lunch, and dinner 2/7/26 breakfast, lunch, and dinner2/8/26 breakfast, lunch, and dinner 2/9/26 dinner 2/10/26 PPM reading for dinner (only temperature recorded)2/11/26 breakfast, lunch, and dinner2/12/26 breakfast and lunch2/13/26 breakfast, lunch, and dinner2/14/26 breakfast and lunch2/15/26 breakfast In an interview, on 02/15/2026 10:24 AM, the DM indicated the test strip must turn a color depth matching between 50 and 100 ppm hypochlorite on the back of the test strip package. He indicated the color produced in the three tests he had just performed indicated an inadequate amount of sanitizer had been dispensed into the dishwasher. He indicated all dishes washed that morning should not be used until rewashed with adequate solution. The DM indicated the dishwasher chemicals should be tested on the first load in correlation with each meal every day. He indicated the dishwasher temperature log should have been filled out for every meal every day. He indicated some staff members were new and not accustomed to testing the dishwasher chemicals as they should. He indicated the chemicals should have been tested on the first load of dishes done that morning. He indicated he did not know why the testing had not been done that morning. In an interview, on 02/15/2026 1:31 PM, DA 2 and DA 4 indicated they had been trained on dishwasher chemical testing, and did not give a reason for not testing the dishwasher chemicals that morning. 2) In an observation, on 02/15/2026 12:26 PM, the DM licked his fingers on his right hand to flip through paper tickets and placed the tickets on meal service trays. The DM then held a serving spoon in his right hand and distributed food to plates, then used his right hand to place plates of food on the food service trays. The DM touched his eye glasses several times during meal service. No hand hygiene had been performed in the process. In an interview, on 02/15/2026 1:28 PM, the DM indicated employees should wash their hands after touching their face, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	glasses, or otherwise contaminating clean hands prior to touching serving utensils or dishes. In an interview on 02/17/2026 2:11 PM the DON indicated all 82 residents were served food prepared in the facility kitchen. A current policy, titled Cleaning Dishes/Dish Machine, dated 2022, provided by the Administrator on 2/15/16 at 8:53 AM, indicated the dish machines should be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. The policy indicated the sanitation cycle should dispense hypochlorite at a concentration of 50 PPM. A current policy, titled Employee Hygiene for Food Safety, undated, provided by the Administrator on 2/15/16 at 8:53 AM, indicated employees should avoid touching their face and mouth during food preparation and should wash hands if they became contaminated.3.1-21(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure physician orders were followed for medications and wound care for 3 of 19 residents reviewed. (Resident 36, Resident 82, and Resident 15)2.A record review for Resident 82 began on 2/16/26 at 11:36 AM. Diagnoses included cellulitis, venous statis ulcers, chronic congestive heart failure, coronary artery disease, and morbid obesity. A review of Resident 82's current admission MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). The MDS indicated the resident had medically complex conditions, coronary artery disease, heart failure, hypertension, a history of sepsis, Parkinson's disease, cellulitis, and morbid obesity. A review of Resident 82's current Care Plan, titled Resident is at Risk for self-care deficits, indicated the resident had a problem of bilateral lower extremity cellulitis. Interventions included staff assistance for dressing, bathing, and transfers. A Care Plan titled at Risk for impaired skin integrity indicated the resident had a problem of bilateral venous ulcers. Interventions included medications/treatments were given as ordered by the physician and staff provided assistance as needed. A review of physician orders, dated 12/4/25-12/17/25, indicated arterial ulcers on Resident 82's right foot, were to be cleansed with wound cleanser, patted dry, xeroform applied, covered with a dressing, and wrapped with rolled gauze every day shift. A review of the Treatment Administration Record (TAR) dated 12/1/25-12/31/25, indicated treatments of arterial ulcers on the right foot were not documented as completed on 12/5/25,12/8/25, 12/12/25, 12/15/25. A review of physician orders, dated 12/3/25-12/17/25, indicated venous ulcers on Resident 82's right calf were to be cleansed with wound cleanser, patted dry, xeroform applied, covered with a dressing, and wrapped with rolled gauze every shift and as needed for soilage or drainage. A review of physician orders, dated 12/18/25-12/30/25, indicated venous ulcers on Resident 82's right calf were to be cleansed with wound cleanser, patted dry, calcium alginate applied, covered with a dressing, and wrapped with rolled gauze. A review of the Treatment Administration Record (TAR) dated 12/1/25-12/31/25, indicated treatment of venous ulcers on resident's right calf were not documented as completed on 12/5/25, 12/8/25, 12/10/25, 12/12/25, 12/15/25, and 12/22/25. A review of progress notes dated 12/1/25-12/31/25, indicated no documentation was completed for wound treatments on 12/5/25, 12/8/25, 12/12/25, 12/15/25, and 12/22/25. 3. During an observation, on 2/19/26 at 10:20 AM, wound care was observed on Resident 15's right posterior knee. A scabbed area, approximately 0.8 cm by 0.5 cm, was surrounded by skin purple in color. A record review for Resident 15 began on 2/15/26 at 11:43 AM. Diagnoses included right sided below (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the knee amputation, diabetes type 2, chronic kidney disease stage 3, peripheral vascular disease, spastic hemiplegia affecting left dominant side. A review of Resident 15's current annual MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). A review of Resident 15's current Care plan, titled At Risk for Impaired psychosocial well-being, sensory deficits, communication deficits, cognitive deficits indicated interventions included staff was to administer medications per physician orders. A review of physician orders dated 2/11/26, indicated the abrasion to the right posterior knee was to be cleansed with wound cleaner, patted dry, and skin prep applied every day shift. A review of the Treatment Administration Record (TAR), dated 2/1/26-2/17/26, indicated treatments of the right posterior knee wound were not documented as completed on 2/13/26 or 2/14/26. A review of physician orders, dated 11/12/25, indicated baclofen 10 mg was to be given by mouth three times a day for muscle spasms at 8:00 AM, 2:00 PM, and 8:00 PM. A review of physician orders, dated 7/17/25, indicated dantrolene sodium 25 mg was to be given by mouth three times a day for musculoskeletal problems at 8:00 AM, 2:00 PM, and 8:00 PM. A review of physician orders, dated 7/5/25, indicated gabapentin 600 mg was to be given by mouth three times a day for peripheral vascular disease at 8:00 AM, 2:00 PM, and 8:00 PM. A review of physician orders, dated 9/4/25, indicated hydrocodone-acetaminophen was to be given by mouth three times a day for chronic pain at 8:00 AM, 2:00 PM, and 8:00 PM. A review of the Medication Administration Record (MAR), dated 2/1/26-2/17/26, indicated Resident 15 did not receive baclofen 10 mg, dantrolene sodium 25 mg, gabapentin 600 mg, hydrocodone-acetaminophen 7.5 mg-325 mg at 2:00 PM on 2/4/26. A review of progress notes, dated 1/30/26-2/19/26, indicated documentation was not completed for medications and/ or wound treatments not given on 2/4/26, 2/13/26, and 2/14/26. In an interview, on 2/19/25 at 11:06 AM, the Director of Nursing indicated scheduled medications and treatments should be documented as given or a reason not given and not left without documentation. A current policy, undated, provided by the Administrator, indicated medications were administered as ordered by the physician. Staff will initial the residents' MAR or TAR after giving each medication. If a medication with withheld, refused, or given at a time other than the scheduled time, the staff administering the medication would initial and circle the MAR space provided for that medication and dose. 3.1-37 1.On 2/17/26 at 2:57 PM, Resident 36 was observed sitting in their wheelchair in their room. Resident 36's feet were resting on foot pedals. Resident 36's right foot was wrapped with an elastic bandage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview, on 2/17/26 at 3:00 PM, Resident 36 requested to have their door closed. Resident 36 indicated the wound on their right foot was not healing. Resident 36 indicated they believed the wound was not healing due to the dressing not being changed every day. Resident 36's record was reviewed on 2/18/26 at 10:58 AM. Diagnoses included heart failure, obesity and swelling of their lower legs. Resident 36 was admitted to the facility for rehabilitation due to fractures of both lower legs. Resident 36's quarterly Minimum Data Set (MDS) indicated their Brief Interview for Mental Status (BIMS) score was 13 (no cognitive loss). Resident 36's Medication Administration Record, (MAR), dated 1/1/26 through 1/31/26, indicated the resident's right foot treatment had not been completed on 1/25/26 and 1/26/26. Resident 36's MAR, dated 2/1/26 through 2/28/25, indicated the resident's right foot treatment had not been completed on 2/6/26, 2/7/26, 2/8/26 and 2/9/26. A weekly skin assessment, dated 1/13/26, indicated Resident 36's right foot wound measured .5 centimeters (cm) long, .5 cm wide and .1 cm deep. A weekly skin assessment, dated 1/20/26, indicated Resident 36's right foot wound measured 2 cm long, .7 cm wide and .1 cm deep. A weekly skin assessment, dated 2/10/26, indicated Resident 36's right foot wound measured 1.9 cm long, 1 cm wide and .1 cm deep. On 2/19/26 at 9:35 AM, Licensed Practical Nurse (LPN) 21 was observed providing wound care to Resident 36's right foot. The wound was rectangular in shape. The wound measured 2.7 cm long, 1.5 cm and .4 cm deep. The wound was red in the middle; the surrounding edges were dark purple. A small amount of clear pink drainage was on the previous dressing. In an interview, on 2/19/26 at 11:06 AM, the Director of Nursing (DON) indicated treatments should be signed after completion. The DON indicated there should be no blank spaces in the MAR unless the nurse documents the reason for the treatment not being done.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safety measures were identified and put into place and hazardous chemicals were stored properly for 3 of 19 residents reviewed. (Resident 1, Resident 35, and Resident 56). Findings include: 1. A record review for Resident 1 began on 2/16/26 at 12:18 PM. Diagnoses included hypertension, seizure disorder, schizoaffective disorder, left side hemiplegia defined as paralysis of one side of the body, post-traumatic stress disorder, and chronic pain. A review of Resident 1's current quarterly MDS, 10/23/25, indicated their BIMS (Basic Interview for Mental Status) score was 13 (cognitively intact). The MDS indicated the resident had medically complex conditions, hypertension, hemiplegia, seizure disorder, anxiety, schizophrenia, post traumatic stress disorder, muscle wasting and atrophy, epilepsy. Resident 1 was taking an antipsychotic, antidepressant, diuretic, opioid, and an anticonvulsant. A review of Resident 1's current Care Plan, titled Resident is at risk for impaired safety/injury, indicated the resident had a problem of falls. Interventions included administering medications as ordered, bed in the lowest position, non-skid footwear, adequate lighting, and reminding resident to use call light. A review of a standard Fall Risk Assessment, Section F, indicated antihypertensive, antiseizure, psychotropic, and diuretic medications increase the risk of falls. Residents that had taken 1-2 high risk medications had a lower fall risk metric than residents that had taken 3-4 high risk medications. Section G indicated predisposed diseases, such as seizures, loss of limbs, stroke, and arthritis. Residents that had 1-2 diseases had a lower risk of falls metric than residents that had 3 or more diseases. A review of a Fall Risk Assessment, dated 1/17/26 at 10:08 AM, indicated Resident 1 had no predisposing disease that elevated the risk of falls. The total Fall Risk Assessment Score was 8, at risk for falls. A review of a Fall Risk Assessment, dated 2/17/26 at 1:55 AM, indicated Resident 1 was ambulatory/continent, had a normal gait/balance, and took 1-2 high risk medications in the last 7 days. The total Fall Risk Assessment Score was 4, not at risk for falls. A review of progress notes, dated 2/17/26 at 1:46PM, indicated the interdisciplinary team determined Resident 1 had fallen asleep in their wheelchair and slid onto the floor on 2/16/26 at 12:30 AM. In an interview, on 2/18/26 at 2:41 PM, LPN 16 indicated Resident1's Fall Risk Assessment Score would be a 10, at risk for falls. Resident 1 was not completely chair bound but used assistive devices to walk. Resident 1 was taking 3-4 high risk medications and had 1-2 predisposed diseases that would have increased the risk of falls. 2. A record review for Resident 35 began on 2/18/26 at 11:00 AM. Diagnoses included Alzheimer's disease, hypertension, and adult failure to thrive. A review of Resident 35's current admission MDS, dated [DATE], indicated their BIMS (Basic (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview for Mental Status) score was 6 (cognitively impaired). The MDS indicated the resident used a wheelchair, needed maximal assistance to stand and transfer from bed to chair, chair to bed, and toileting. A review of Resident 35's current Care Plan titled Resident is at risk for falls indicated Resident 35 had impaired safety related to malnutrition, weakness, and a history of frequent falls, dated 12/06/2025. A review of a standard Fall Risk Assessment, Section A indicated intermittent confusion elevated the risk of falls. Section B indicated 3 or more falls in the past 3 months elevated the risk of falls. Section G indicated predisposed diseases, such as seizures, loss of limbs, stroke, and arthritis had a higher risk of falls. A review of progress notes, dated 12/8/25 at 1:05 PM, indicated the interdisciplinary team determined Resident 35 rolled out of bed. A review of a Fall Risk Assessment, dated 12/8/25 at 2:00 PM, indicated Resident 35 was alert and oriented and no falls had occurred in the last 3 months. The total Fall Risk Assessment Score was 8, at risk for falls. A review of a Fall Risk Assessment, dated 1/8/26 and 1:44 PM, indicated Resident 35 had no predisposing diseases that elevated the risk of falls. The total Fall Risk Assessment Score was 16, at risk for falls. A review of progress notes, dated 12/26/25 at 8:52 AM, indicated the interdisciplinary team determined Resident 35 had slid out of their wheelchair and was found lying on the floor in the dining room on 12/23/25. A current policy, dated 10/20/2023, provided by the Administrator, indicated risk for falls assessments were to be completed after a fall. Data from the fall risk assessment was used to develop and implement a resident centered fall plan of care. Fall Risk Factors include resident specific conditions and medical factors such as cognitive impairment, pain, weakness of extremity strength, side effects of medications, functional impairments, incontinence, seizure disorder, neurological conditions, balance, and gait disorders. 3) During an observation, on 02/15/2026 12:40 PM, an opaque white bottle labeled bleach and a clear plastic bottle about 1/2 full of purple liquid, labeled Fabuloso (a chemical cleaning product) were observed on the bedside table in Resident 56's room. A large can labeled Raid ant spray was observed on the window ledge in Resident 56's room. Two buckets about half full of murky grey liquid were observed next to the door inside Resident 56's room. One of the buckets contained a mop. Resident 56's room had a strong chemical odor. In an interview, on 02/15/2026 12:41 PM, Resident 56 indicated he had high standards for cleanliness. He indicated his small grandchildren visited regularly and touched the floor. Resident 56 indicated he had prayer mats that he placed on the floor so his family may pray while visiting. Resident 56 indicated he wanted his floor to be clean and staff did not complete cleaning tasks to his standards. Resident 56 indicated housekeeping did not clean his room on the weekends. During an interview on 02/15/2026 12:56 PM, the Environmental Services Director (ESD) indicated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 56 frequently refused to have housekeepers clean his room. The ESD indicated bleach, chemical cleaning products, and ant spray contained hazardous chemicals and should be stored in secured areas, only accessible by authorized personnel. Resident 56's record was reviewed on 02/17/2026 12:15 PM. Diagnoses included bipolar disorder with rapid mood cycling. A current quarterly Minimum Data Set (MDS) assessment, dated 12/4/25, indicated Resident 56 had a Basic Interview for Mental Status (BIMS score of 15 (cognitively intact). A current policy, titled Storage of Hazardous Chemicals, provided by the Administrator on 2/16/26 at 8:53 AM, indicated hazardous chemicals should be properly labeled, securely stored in a manner to prevent accidental exposure, contamination, misuse, or injury. The policy indicated hazardous chemicals should be inaccessible to residents at all times. 3.1-45(a)(1) 3.1-45(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure oxygen was administered according to physician's orders for 1 of 1 residents reviewed (Resident 5).Findings include:During an observation, on 02/18/2026 10:18 AM, a portable oxygen tank was observed at Resident 5's bedside. The tank was set to deliver 5 liters of oxygen per minute. Resident 5 was not in his room. On 02/18/2026 10:21 AM, Resident 5 was observed propelling his motorized w/c with no oxygen on. In an interview, on 02/18/2026 10:22 AM, Assistant Director of Nursing (ADON) 6 indicated she did not know why Resident 5 did not have his oxygen in place. Resident 5's record was reviewed on 02/18/2026 10:40 AM. Diagnoses included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. A current admission Minimum Data Set (MDS)assessment, dated 11/17/25, indicated Resident 5 had a Basic Interview for Mental Status (BIMS) score of 9 (cognitively impaired). The MDS indicated Resident 5 used oxygen. A physician order, dated 11/8/2025, indicated Resident 5 should receive oxygen at 4 liters per minute via a nasal cannula continuously. Progress notes, dated January and February 2026, did not include any documentation of refusal of oxygen. Resident 5's care plan did not address oxygen use or any refusal to use oxygen. Resident 5's current certified nurse aide assignment sheet (Kardex), provided by the Administrator on 2/18/26 at 12:46 PM, indicated Resident 5 should be provided oxygen according to physician's orders. A Medication and Treatment record, dated February 2026, indicated Resident 5 received oxygen at 4 lpm via nasal cannula continuously each day without any record of refusal. In an interview, on 02/18/2026 11:14 AM, Certified Nurse Aide 8 indicated Resident 5 used his oxygen off and on and managed oxygen use himself. In an interview, on 02/18/2026 11:18 AM, Licensed Practical Nurse 12 indicated Resident 5 only used his oxygen at night. She indicated Resident 5 did not use oxygen during the day because he propelled himself around the building and frequently went outside to smoke. In an interview, on 02/18/2026 11:20 AM, ADON 10 indicated any resident receiving oxygen should have oxygen use addressed on their care plan. She indicated any refusal of continuous use by the resident should result in notification of the physician or nurse practitioner, assessment of oxygen saturation levels, education for the resident and updating of the care plan if the resident chooses not to accept continuous use as ordered. In an interview, on 02/18/2026 11:22 AM, ADON 6 indicated Resident 5 did what he wanted to in regards to his oxygen use. A current policy titled Oxygen Administration, undated, provided by the Administrator on 2/18/26 at 11:08 AM, indicated physicians orders and care plans should be reviewed by staff providing oxygen to residents. The policy indicated refusal, reason for refusal, and interventions taken. The policy indicated staff should notify the supervisor of refusal. 3.1-47(a)(6)